STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint #IN00091997. Complaint #IN00091997 Substantiated. Federal/state deficiencies related to the allegation are cited at F323 and F514. Survey dates: June 20-22, 2011 Facility number: 000014 Provider number: 155039 Aim number: 100288670 Survey team: Honey Kuhn, RN Census bed type: SNF: 17 SNF/NF: 53 Total: 70 Medicare: 18 Medicaid; 39 Private: 13 Total: 70 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/24/11	F0000	Please accept this as our credible allegation of compliance.We respectfully request consideration for paper compliance related to the following plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Cathy Emswiller RN			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on record reviews and interviews, the facility failed to ensure the safety of 1 of 1 resident's who incurred a fall for 1 of 3 residents reviewed for falls in a sample of 3. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 06/20/11 at 10: 45 a.m. Resident "C" was admitted to the facility, on 06/10/11 at 9:15 p.m., with diagnoses including, but not limited to, esophageal cancer with metastasis and hypertension. Review of admission orders indicated hospice services had been arranged prior to discharge from an ACF (Acute Care Facility: hospital). Review of the record indicated the resident was weak, debilitated, and had incurred falls both prior to and while a patient in the ACF. The pre-admission information indicated the resident had received the terminal diagnosis less than 2 weeks prior, and, despite a palliative consultation, physician discussions, comfort measures only and Hospice services which addressed the	F0323	It is the policy of Miller's Merry manor - Peru to ensure that the residents environment remains as free of accident hazards as is possible and that each resident receives adequate supervison and assistance devices to prevent accidents.Resident "C" was in a low bed with a concave mattress and floor mat to prevent injuries. A bed alarm was placed following his fall. He was checked every two hours per policy. Resident "C" expired on 6/15/11 with no further falls.All new admissions who are identified as "at risk for falls" have the potential to be affected by this deficient practice and will be identified through a facility review and audit and a pre-admission assessment.In order to prevent this deficient practice from recurring - all new admissions who have been deemed a fall risk during the pre-admission assessment will have a "Fall Assessment" (Exhibit #1) completed "upon admission" so that fall "Interventions/Protocol" can be implemented timely.All nursing staff were inserviced at a mandatory meeting on 6/30/11	07/08/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	terminal diagnosis, the family remained unaccepting of the diagnosis and were "praying for a miracle." The resident's medications included, but were not limited to: "Dilaudid 1.5 mg (milligrams) IV (intravenous) q (every) 4 hours PRN (as needed) for pain." "Roxinal 3 mg PO (Per Os: by mouth)/SL (Sublingual: under the tongue) q 1* (hour) for pain." "Lorazapam 0.25 mg PO q 6* PRN anxiety." "Lorazapam 0.5 mg PO q 6* PRN anxiety." "Haloperidol 5 mg IM (intramuscularly: shot) or IV q 4* as needed for agitation." The "Admission Information" form, dated 06/10/2011 at 19:15 (7:15 p.m.) (arrival time) was reviewed. Interview with the ADNS (Assistant Director Nursing Services), on 06/20/11 at 1:00 p.m., indicated the form should have indicated arrival time as 21:15 (9:15 p.m.). The ADNS provided a 24-hour report form that indicated the resident arrived at 9:15 p.m. The admission forms indicated the following resident information: "Speech/Communication:...2. Unclear speech (slurred, mumbled words..." "Mental Status Assessment: Alert and Oriented to: 1. Self 2. Situation 3. Place 4. Time...8. Lethargic/Drowsy..."		(Exhibit #2) on the importance of accurately and completely documenting sufficient information on each resident on a timely basis and the Fall Management program. The inservice included a review of the following policies and procedures: 1. Charting Procedure - Exhibit #3 2. New Admission and Return to Facility Procedure - Exhibit #4 3. Fall Managment - Exhibit #5 4. Incident and Accident Report Procedure - Exhibit #6 5. Intervention/Protocol List - Exhibit #7 6. Post Fall Investigation - Exhibit #8 7. Narrative charting a minimum of two (2) times per shift for 3 days on all new admissions and more frequently if condition or situation warrants - Exhibit #9Review of these policies and procedures will assist in ensuring that staff are following established procedures for accurate, complete and timely documention.To ensure compliance with the system and policies - the DON and/or designee will the complete the QA Tool - "Falls Risk Management Review" (Exhibit #10) and "Admission Audit" (Exhibit #11) on all new admissions identified as a fall risk daily times 2 weeks, then weekly times 4 weeks and monthly there after per protocol. The results will be documented and reviewed by the facility Quality Assurance committee during monthly meetings.Charge	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Pain Assessment: 1. Is resident experiencing pain...Yes 2. Location: sub sternal and middle of back...3. Pain scale: 3-5 (hurts a little more... (electronic signature of LPN #2" The form did not address falls. Interview with the ADNS indicated a separate "Fall Assessment" is to be done within 8 hours of admission. The ADNS indicated standard fall prevention measures were put into effect at admission, which included a low bed, a concave mattress and a fall mat (a mat placed next to mattress to prevent injury). The ADNS indicated bed alarms are not placed prior to a fall. Review of Progress Notes (Nurses notes) following admission indicated the first 3 entries: "06/11/2011 07:05 call placed to hospice nurse (name) and notified of res fall with abrasions and of res being non verbal at this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here d/t she was up all night and could use her rest and will be in to facility this am.		nurses responsibleDON and/or Designee will monitor compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(electronic signature of day nurse: LPN #3)" "06/11/2011 08:15 Family here and notified of res falls X 2 with abrasions and weakened grip on right side. Also notified that res given PRN pain med per orders after rolling out of be onto floor. Family very distraught and stated this is a big change from yesterday. Stated yesterday res was able to sit up on side of bed unassisted and was talking without difficulty. Writer explained that res had been nonverbal since writer got here this am and explained that it took 3 staff and a hoyer lift to assist res back to his bed after fall. Writer assured family that we would keep res as comfortable as possible and told her that we had notified Hospice and they would be here around 9 am to assess res. Res resting quietly in bed with family and friends at bedside at this time. (electronic signature of day nurse: LPN #3)" The ADNS, during the interview, indicated a resident fall would not be recorded in the Progress Notes but on an "Occurrence Initial Assessment". Review of "Occurrence Initial Assessment" forms for the 2 falls, were reviewed with the record of Resident "C" and indicated: Occurrence #1: "1. Time: 06/11/2011 06:30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Location: res (resident's) room 3. Found res lying on floor in front of bathroom door" Vital signs were recorded and neuro checks (checking of grips, pupils, orientation) were started....7. Complete head to toe assessment,...f. abrasion...j. Describe all injuries noted above: 2 cm (centimeter) X (by) 1 cm abrasion to right inner foot. 3 abrasions to left knee measuring as follows: 3.3 cm X 1.7 cm, 1 cm X 1 cm, and 3.5 cm X 1.8 cm ; also noted 5 cm X 3 cm reddened area to right cheek. The physician was notified. (day nurse electronic signature: LPN #3)" Occurrence #2: "1. Time: 08:00 2. Location: res room 3. res bed alarm going off and res found sitting on mat on floor beside bed. res appearing agitated and restless. PRN pain med given for s/s (sign/symptoms) pain" Vital signs (V/S) and neuro checks continued. No new injuries noted. (day nurse electronic signature: LPN #3)" Review of a "Post Fall Investigation" by the facility indicated: The fall occurred on 06/11/11 at 6:30 a.m. The resident was noted to have fallen within 30 days. Resident "C" appeared to be attempting to ambulate to the bathroom and "was in bed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and got up and tried to get to bathroom" Resident "C" was noted to be incontinent at the time of the fall. No staff were present at the time of the fall. The form was signed as reviewed by the ADNS on 06/20/11. The ADNS was queried on 06/22/11 in regards to the "Post Fall Investigation". The ADNS indicated the form was completed by another staff member. The investigation indicated a bed alarm was in place but it was a recording error and the alarm was placed after the fall. The ADNS indicated staff members fill out the Post Fall Investigation forms. The ADNS was queried if Administrative staff further interviewed staff members for when the resident was last checked, toileted, etc. The ADNS indicated the protocol did not indicate for further investigation to be done. Review of the record for Resident "C" indicated the Hospice nurse arrived at the facility and did an admission assessment on 06/10/11 at 9:30 p.m. The hospice assessment indicated the resident required the assist of 1 person for transfer, ambulation, and toileting. Resident "C" was assessed as being in frequent pain and a fall assessment indicated the resident was a "High Risk" for falls. The information indicated the Hospice nurse conference with the LPN #2 prior to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	exiting the facility. Interview with the ADNS, on 06/21/11 at 10:00 a.m. indicated the resident was checked by staff and repositioned every 2 hours following admission. The ADNS indicated the PRN medication sheet indicated how Resident "C" was responding to medications for pain and/or agitation/anxiety during the time following admission until the 1st Progress Note entry at 7:05 a.m. on 06/11/11 by LPN #3. LPN #3 was interviewed on 06/21/11 at 11:00 a.m. LPN #3 indicated she was informed upon arrival to her unit Resident "C" had rolled out of bed and incurred a fall earlier during night shift. LPN #3 indicated she was summoned to assess Resident "C" and then notified the Hospice nurse by phone. The Hospice nurse directed her not to notify the family until their anticipated arrival the morning of 06/11/11. LPN #3 indicated Resident "C" had a rapid decline after admission. LPN #2, the nurse who completed the admission assessment, was unavailable for interview. The PRN medication sheets, from admission through 06/15/11, were reviewed on 06/21/11 at 11:00 a.m.. The documentation indicated Resident "C"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was medicated for pain and nausea on 06/11/11 at 12:45 a.m. by the Hospice nurse. The resident was noted by the Hospice nurse to be resting/sleeping at 1:30 a.m. The next entry was 06/11/11 at 8:00 a.m. when Resident "C" was medicated for pain and the resident was noted to be "sleeping eyes shut" at 8:05 a.m. by LPN #2. The record did not contain information to indicate Resident "C" was observed between 1:30 a.m. and 6:30 a.m., prior to or following the 1st fall. Review of a facility Policy and Procedure, titled, "Interventions to Reduce Fall Risk-09/01/2004" indicated: "...3. Staff Routine: a. Anticipate care needs for confused residents..." Review of a facility Policy and Procedure, titled, "Charting Procedure-11/02/20010" indicated: 1. Purpose: A. To accurately document in an organized manner all pertinent information related to the resident in the medical record...." This Federal tag relates to Complaint #IN00091997. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to follow the facility's policy and procedure in regards to 1 of 1 resident who fell in a sample of 3 residents reviewed for falls and documentation. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 06/20/11 at 10: 45 a.m. Resident "C" was admitted to the facility, on 06/10/11 at 9:15 p.m., with diagnoses including, but not limited to, esophageal cancer with	F0514	It is the policy of Miller's Merry Manor - Peru to ensure that clinical records are complete and accurately documented.Resident "C" expired on 6/15/11All residents have the potential to be affected by this deficient practice and will be identified through review of the Daily Condition Report (Exhibit # 12) and subsequent review by the DON/designee of documentation of any significant changes to ensure that documentation/assessments are accurate, complete and timely.All nursing staff were inserviced at a	07/08/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	metastasis and hypertension. Review of admission orders indicated hospice services had been arranged prior to discharge from an ACF (Acute Care Facility: hospital). Review of the record indicated the resident was weak, debilitated, and had incurred falls both prior to and while a patient in the ACF. The "Admission Information" form, dated 06/10/2011 at 19:15 (7:15 p.m.) (arrival time) was reviewed. Interview with the ADNS (Assistant Director Nursing Services), on 06/20/11 at 1:00 p.m., indicated the form should have indicated arrival time as 21:15 (9:15 p.m.). The ADNS provided a 24-hour report form that indicated the resident arrived at 9:15 p.m. The admission forms indicated the following resident information: "Speech/Communication:...2. Unclear speech (slurred, mumbled words..." "Mental Status Assessment: Alert and Oriented to: 1. Self 2. Situation 3. Place 4. Time...8. Lethargic/Drowsy..." "Pain Assessment: 1. Is resident experiencing pain...Yes 2. Location: sub sternal and middle of back...3. Pain scale: 3-5 (hurts a little more... (electronic signature of LPN #2" The form did not address falls. Interview with the ADNS indicated a separate "Fall Assessment" is to be done within 8 hours		mandatory meeting on 6/30/11 (Exhibits # 2-9).Review of these policies and procedures will assist in ensuring that staff are following established procedures for accurate, complete and timely documention.To monitor compliance - the DON/designee will be responsible for completion of the QA Tool "On-going Medical Records Audit" (Exhibit #13) daily times 2 weeks, then weekly times 4 weeks and monthly thereafter per protocol. Any identified trends will be reviewed by the Quality Assurance committee during monthly meetings.Charge nurses responsibleDON and/or Designee will monitor compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of admission. The ADNS indicated standard fall prevention measures were put into effect at admission, which included a low bed, a concave mattress and a fall mat (a mat placed next to mattress to prevent injury). The ADNS indicated bed alarms are not placed prior to a fall. Review of Progress Notes (Nurses notes) following admission indicated the first 3 entries: "06/11/2011 07:05 call placed to hospice nurse (name) and notified of res fall with abrasions and of res being non verbal at this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here d/t she was up all night and could use her rest and will be in to facility this am. (electronic signature of day nurse: LPN #3)" "06/11/2011 08:15 Family here and notified of res falls X 2 with abrasions and weakened grip on right side. Also notified that res given PRN pain med per orders after rolling out of be onto floor.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Family very distraught and stated this is a big change from yesterday. Stated yesterday res was able to sit up on side of bed unassisted and was talking without difficulty. Writer explained that res had been nonverbal since writer got here this am and explained that it took 3 staff and a hoyer lift to assist res back to his bed after fall. Writer assured family that we would keep res as comfortable as possible and told her that we had notified Hospice and they would be here around 9 am to assess res. Res resting quietly in bed with family and friends at bedside at this time. (electronic signature of day nurse: LPN #3)" The ADNS, during the interview, indicated a resident fall would not be recorded in the Progress Notes but on an "Occurrence Initial Assessment". Review of "Occurrence Initial Assessment" forms for the 2 falls, were reviewed with the record of Resident "C" and indicated: Occurrence #1: "1. Time: 06/11/2011 06:30 2. Location: res (resident's) room 3. Found res lying on floor in front of bathroom door" Vital signs were recorded and neuro checks (checking of grips, pupils, orientation) were started....7. Complete head to toe assessment,...f. abrasion...j. Describe all injuries noted above:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2 cm (centimeter) X (by) 1 cm abrasion to right inner foot. 3 abrasions to left knee measuring as follows: 3.3 cm X 1.7 cm, 1 cm X 1 cm, and 3.5 cm X 1.8 cm ; also noted 5 cm X 3 cm reddened area to right cheek. (day nurse electronic signature: LPN #3)" Occurrence #2: "1. Time: 08:00 2. Location: res room 3. res bed alarm going off and res found sitting on mat on floor beside bed. res appearing agitated and restless. PRN pain med given for s/s (sign/symptoms) pain" Vital signs (V/S) and neuro checks continued. No new injuries noted. (day nurse electronic signature: LPN #3)" Review of a "Post Fall Investigation" by the facility indicated: The fall occurred on 06/11/11 at 6:30 a.m. The resident was noted to have fallen within 30 days. Resident "C" appeared to be attempting to ambulate to the bathroom and "was in bed and got up and tried to get to bathroom" Resident "C" was noted to be incontinent at the time of the fall. No staff were present at the time of the fall. The form was signed as reviewed by the ADNS on 06/20/11. The ADNS was queried on 06/22/11 in regards to the "Post Fall Investigation". The ADNS indicated the form was completed by another staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member. The investigation indicated a bed alarm was in place but it was a recording error and the alarm was placed after the fall. The ADNS indicated staff members fill out the Post Fall Investigation forms. The ADNS was queried if Administrative staff further interviewed staff members for when the resident was last checked, toileted, call lights, etc. The ADNS indicated the protocol did not indicate further investigation to be done to address falls. Review of the record for Resident "C" indicated the Hospice nurse arrived at the facility and did an admission assessment on 06/10/11 at 9:30 p.m. The hospice assessment indicated the resident required the assist of 1 person for transfer, ambulation, and toileting. Resident "C" was assessed as being in frequent pain and a fall assessment indicated the resident was a "High Risk" for falls. The information indicated the Hospice nurse conferenced with LPN #2 prior to exiting the facility. Interview with the ADNS, on 06/21/11 at 10:00 a.m. indicated the resident was checked by staff and repositioned every 2 hours following admission. The ADNS indicated the PRN medication sheet indicated how Resident "C" was responding to medications for pain and/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	agitation/anxiety during the time following admission until the 1st Progress Note entry at 7:05 a.m. on 06/11/11 by LPN #3. LPN #3 was interviewed on 06/21/11 at 11:00 a.m. LPN #3 indicated she was informed upon arrival to her unit Resident "C" had rolled out of bed and also had incurred a fall earlier during night shift. LPN #3 indicated she was summoned to assess Resident "C" and then notified the Hospice nurse by phone. The Hospice nurse directed her not to notify the family until their anticipated arrival the morning of 06/11/11. LPN #3 indicated Resident "C" had a rapid decline after admission. LPN #2, the nurse who completed the Admission assessment, was unavailable for interview. The PRN medication sheets, from admission through 06/15/11, were reviewed on 06/21/11 at 11:00 a.m.. The documentation indicated Resident "C" was medicated for pain and nausea on 06/11/11 at 12:45 a.m. by the Hospice nurse. The resident was noted by the Hospice nurse to be resting/sleeping at 1:30 a.m. The next entry was 06/11/11 at 8:00 a.m. when Resident "C" was medicated for pain and the resident was noted to be "sleeping eyes shut" at 8:05 a.m. by LPN #2. The record did not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contain information to indicate Resident "C" was observed between 1:30 a.m. and 6:30 a.m., prior to or following the 1st fall. There was documentation by the night shift nurse, LPN #2, in regards to the fall on 06/11/11 at 6:30 a.m. on either Progress Notes or the Occurrence form to indicate circumstances prior to or following the fall. Review of a facility Policy and Procedure, titled, "Charting Procedure-11/02/20010" indicated: 1. Purpose: A. To accurately document in an organized manner all pertinent information related to the resident in the medical record...." 2. Pertinent Charting: A. documentation will be completed for all pertinent issues either in progress notes or in the assessment module of the EMR (Electronic Medical Record). Includes, but is not limited to the following: I. Any incident or accident occurrence or follow-up occurrence will be documented on the EMR form titled "Nursing occurrence pintail" or Nursing occurrence follow-up. II. Any physical or emotional symptom or complaint will be documented in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	317 BLAIR PIKE PERU, IN46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	progress notes. Any condition change will be documented in the progress notes...." This Federal tag relates to Complaint #IN00091997. 3.1-50(a)(1) 3.1-50(a)(2)			